Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN3144HHA	A. BUILDING _____ B. WING _____	05/27/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAHOE FOREST HOME HEALTH SVC	10098 PINE AVE STATELINE, NV 89449

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 00	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of a State Licensure Survey conducted in your facility on May 26, 2009 and finalized on May 27, 2009, in accordance with Nevada Administrative Code, Chapter 449, Home Health Agencies. A Plan of Correction (POC) must be submitted. The POC must relate to the care of all patients and prevent such occurrences in the future. The intended completion dates and the mechanism(s) established to assure ongoing compliance must be included. Monitoring visits may be imposed to ensure on-going compliance with regulatory requirements. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. The census at the time of the survey was one. Five clinical records were reviewed. The following deficiencies were identified:	H 00		
H125	449.768 Home Office in Nevada A person who applies for a license to operate a home health agency or a person who holds such a license shall maintain a home office in this state. This Regulation is not met as evidenced by: Based on license review and staff interview, the agency failed to a home office in this state.	H125	H125 449.768 1. A Home office was established at Incline Village Community Hospital at 880 Alder Ave, Incline Village, NV 89451. 2. A Mandatory staff meeting was held to review the process for the appropriate utilization of the home office in Nevada. 3. The Office Manager shall audit the Nevada office utilization x 4 weeks to verify procedures are being properly followed by staff. 4. The Home Health Administrative Director is working directly with the bureau on correcting licensure.	6/17/09 6/16/09 7/14/09 8/7/09

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Chief Executive Officer — (X6) DATE: 6/18/09

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H125	Continued From page 1 Findings include: Review of the license to operate a home health agency in Nevada, located in the Truckee California location of the home health agency, revealed a Truckee address with a Stateline, Nevada town listed. There was no listing for the town of Stateline with the address on the license. Interview with the Home Health Program Director on 5/26/09, revealed that there was not an office located in the state of Nevada. Severity 1, scope 1	H125	H128 449.770 1. The Board of Directors Bylaws were revised to include representation from each of the professional disciplines, and at least two (2) members of the community at large. 2. The revised Bylaws are scheduled for review and approval at the July 28th, Board of Directors meeting. 3. The proposed Professional Advisory Committee membership will be reviewed and appointed at the June 30th, Board of Directors meeting. Membership includes: • Home Health Administrative Director • Home Health Medical Director • Staff Registered Nurse • Physical Therapist • Occupational Therapist • Speech Therapist • Medical Social Worker • Two (2) Community Members	6-12-09 7-28-09 6-30-09
H128	449.770 Governing Body; Bylaws 3. The governing body shall appoint an advisory group of professional personnel, including one or more members who are practicing physicians, one or more professional registered nurses and representatives from other professional disciplines as indicated by the scope of the agency's program. This Regulation is not met as evidenced by: Based on document review and staff interview, the agency failed to appoint members to the advisory group of professional personnel that included representatives from the professional disciplines as indicated by the scope of the agency's program. Findings include: Review of the minutes of the Professional Advisory Group revealed that only one representative was on the group to represent all of the therapy services being provided by the agency. This was confirmed by the Home Health Program Director on 5/27/09 at 10:55 AM during interview.	H128		

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H128	Continued From page 2 Severity 1, scope 1	H128		
H141	449.779 Professional Advisory Group 2. The professional advisory group must include at least one member who is a practicing physician, one professional registered nurse, representatives from other professional disciplines as indicated by the scope of the agency's program and two members who are representatives of the general public served by the agency. At least one member of the advisory group may not be an owner or employee of the agency. The administrator or his designee shall attend all meetings of the advisory group. This Regulation is not met as evidenced by: Based on document review and staff interview, the agency failed to include on the professional advisory group representatives from all professional disciplines as indicated by the scope of the agency's program. Findings include: Review of the minutes of the Professional Advisory Group revealed that only one representative was on the group to represent all of the therapy services being provided by the agency. This was confirmed by the Home Health Program Director on 5/27/09 at 10:55 AM during interview. Severity 1, scope 1	H141	H141 449.779 1. Policies and procedures for the Professional Advisory Group (PAG) were revised to reflect membership from each of the professional disciplines. 2. The Board of Directors Bylaws were revised to include representation from each of the professional disciplines, and at least two (2) members of the community at large. 3. The revised Bylaws are scheduled for review and approval at the July 28th, Board of Directors meeting. 4. The proposed Professional Advisory Committee members, including two (2) community members and representation from each of the professional disciplines, will be reviewed and appointed at the June 30th, Board of Directors meeting. Membership includes: • Home Health Administrative Director • Home Health Medical Director • Staff Registered Nurse • Physical Therapist • Occupational Therapist • Speech Therapist • Medical Social Worker • Two (2) Community Members	6-4-09 6-12-09 7-28-09 6-30-09
H142	449.779 Professional Advisory Group	H142		

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H142	Continued From page 3 3. The advisory group shall meet at regular intervals, but at least once a year. Dated minutes must reflect an evaluation of overall agency performance, including the availability of services, the utilization of services and the quality of services. Recommendations must be forwarded to the governing body. This Regulation is not met as evidenced by: Based on documentation review and staff interview, the agency failed to have the Professional Advisory Group meet at least once a year, in the year 2008. Findings include: Review of the minutes of the Professional Advisory Group revealed that there were no minutes for the year 2008. This was confirmed by the Home Health Program Director on 5/27/09 at 10:55 AM during interview. Severity 1, scope 1	H142	H142 449.779 1. The members of the proposed Professional Advisory Group met on June 17, 2009 to conduct an annual evaluation of overall agency performance, including the availability of services, utilization of services and quality of services. 2. The Professional Advisory Group meeting minutes were forwarded to the executive assistant for inclusion in the Board of Directors packets on June 18, 2009. 3. The Professional Advisory Group minutes and recommendations will be reviewed at the Board of Directors meeting on June 30, 2009. 4. The Professional Advisory Group meeting will be scheduled minimally on an annual basis, or more frequently as needed.	6/17/09 6/18/09 6/30/09 6/17/09
H152	449.782 Personnel Policies A home health agency shall establish written policies concerning the qualification, responsibilities and conditions of employment for each type of personnel, including licensure if required by law. The written policies must be reviewed as needed and made available to the members of the staff and the advisory groups. The personnel policies must provide for: 6. The maintenance of employee records which confirm that personnel policies are followed; This Regulation is not met as evidenced by: Based on record review it was determined that the agency failed to comply with NRS 449.179 for 11 of 11 employees. (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10 and #11)	H152		

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H152	Continued From page 4 Findings include: The Nevada Revised Statutes, under chapter 449 requires the following: Nevada Revised Statutes 449.179 "Except as otherwise provided in subsection 2, within 10 days of hiring an employee or entering into a contract with an independent contractor, the administrator of, or the person licensed to operate, an agency to provide nursing in the home, a facility for intermediate care, a facility for skilled nursing or a residential facility for groups shall: (a) Obtain a written statement from the employee or independent contractor stating whether he has been convicted of any crime listed in NRS 449.188; Employees #1, #2, #3, #5, #6, #7, #8, #9, #10 and #11: During personnel file review the employees did not have a written statement in their personnel file stating whether he has been convicted of any crime as required in NRS 449.188. The most recently hired of these employees was Employee #3, with a date of hire of 2/3/06. NRS 449.179(3) Initial and periodic investigations of criminal history of employee or independent contractor of certain agency or facility. 3. The administrator of, or the person licensed to operate, an agency to provide personal care services in the home, an agency to provide nursing in the home, a facility for intermediate care, a facility for skilled nursing or a	H152	H152 449.782 1. All home health agency staff received a written statement to complete indicating whether he/she has been convicted of any crime listed in NRS 449.188. — 5/29/09 2. An audit tool was developed to monitor the return of the written statements from each provider. — 6/1/09 3. Staff was notified at the mandatory Home Health meeting that it was a requirement in the state of Nevada to obtain a written statement from each staff member, in compliance with NRS 449.188. Staff members were informed that this must be completed before being permitted to see patients in Nevada. — 6/16/09 4. The original document will be maintained in each staff member's personnel file in Human Resources. — 6/18/09 5. The Administrative Director will monitor compliance and report any non-compliance at the QA/UR quarterly meeting — 7/29/09 6. Human resources will include the NRS 449.188 written statement as part of the new hire process for Home Health employees/independent contractors, to be completed within 10 days of hire and before any patient contact. — 6/18/09 Ongoing	

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H152	Continued From page 5 residential facility for groups shall ensure that the criminal history of each employee or independent contractor who works at the agency or facility is investigated at least once every 5 years. The administrator or person shall: (a) If the agency or facility does not have the fingerprints of the employee or independent contractor on file, obtain two sets of fingerprints from the employee or independent contractor; (b) Obtain written authorization from the employee or independent contractor to forward the fingerprints on file or obtained pursuant to paragraph (a) to the Central Repository for Nevada Records of Criminal History for submission to the Federal Bureau of Investigation (FBI) for its report; and (c) Submit the fingerprints to the Central Repository for Nevada Records of Criminal History. Employees #1, #2, #3, #4, #5, #6, #7, #8, #9, #10 and #11: During personnel file review the files lacked documented evidence of results of fingerprint searches for the FBI and the Nevada records central repository. Severity 2, scope 2	H152	H 152 NRS 449.179 (3) 1. All Home Health staff members were notified to have fingerprints completed to meet the State of Nevada requirement. 2. Staff was informed at the mandatory Home Health meeting that each staff member must be fingerprinted for a criminal history check (initially and at least every five years) and a copy of their fingerprints with documented evidence of fingerprint searches be maintained in their personnel file, in order to be in compliance with Nevada regulations. Employees were advised they will not be permitted to see patients in Nevada until fingerprints are completed. 3. All staff signed written authorization to send fingerprints to the Central Repository for Nevada Records of Criminal History for submission to the FBI for its report. 4. A Copy of fingerprints for each staff member with proof of criminal check findings will be maintained in the Human Resources personnel file. 5. Humans resources will track fingerprints due dates on HR software and inform the Home Health Administrative Director and the employee prior to the five year expiration date. 6. Human resources will incorporate fingerprinting for a criminal history check into the new hire process for Home Health employees.	5/29/09 6/16/09 6/17/09 8/7/09 6/17/09 6/18/09 — Ongoing
H169	449.791 Duties of Personnel 1. A registered nurse shall: (a) Provide nursing guidance and care to patients at home. (b) Evaluate the home for its suitability for the patient's care. (c) Teach the patient and those in the home who nurse him how his care is to be given. (d) Supervise and evaluate the patient's care on a continuing basis. (e) Provide necessary professional nursing	H169		

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H169	Continued From page 6 care. This Regulation is not met as evidenced by: Based on clinical record review, the agency failed to have registered nursing staff supervise the home health aides which includes updated home health aide care plans for 1 of 5 patients sampled. (#3) Findings include: Patient #3 was admitted to the agency on 4/24/09 with diagnoses of aftercare following orthopedic surgery, abnormality of gait and hypertension. Though care for a pressure ulcer was mentioned in the body of the plan of care, there was no diagnosis to support it. Patient #3 was seen by the home health aide during the episode of care five times, the order for the home health aide did not appear on the plan of care dated 4/24/09. The care plan written by the assigning registered nurse did not include instructions for oral hygiene or shaving. Oral hygiene was addressed for each visit the home health aide made, except for two, as being provided to the patient. The clinical record lacked documented evidence that the issue had been addressed by the registered nurse with the home health aide during the supervisory visit. Severity: 2, scope: 1	H169	H 169 449.791 1. Post survey, an order was located for patient #3 indicating the diagnosis and dressing change ordered and signed by the physician (See attached order). 2. The responsible nurse was counseled regarding the need to properly complete an individualized care plan for Patient #3. 3. The responsible nurse was counseled regarding the lack of supervision provided to the home health aide. 4. Physician notified of error and need to correct the plan of care for patient #3 5. Plan of care corrected with proper dates for home health aide frequency. 6. The Home Health Aide received coaching on following the individual written plan of care and accurately documenting care provided. 7. The responsibilities of the nurse to review the plan of care with the Home Health Aide and the need to provide direction during supervised visits was reinforced at the mandatory Home Health meeting. 8. Home health aide documentation will be audited weekly for four weeks to verify compliance with the plan of care. 9. Administrative Director will monitor compliance and report audit results at QA/UR meeting on July 29, 2009.	6/18/09 6/15/09 6/15/09 6/15/09 6/15/09 6/12/09 6/16/09 7/18/09 7/29/09
H192	449.797 Contents of Clinical Records 9. A report given to the attending physician, written or by phone, whenever unusual findings occur. A written progress note must be submitted the physician at least every 62 days. This Regulation is not met as evidenced by:	H192		

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H192	Continued From page 7 Based on clinical record review, the agency failed to provide a discharge summary that met the definition for a written progress note in 4 of 5 patients sampled. (#1, #2, #3 and #4) Findings include: Progress note means a written notation, dated and signed by a member of the health team, that summarizes facts about care furnished and the patient's response during a given period of time. Patient #1 was admitted to the agency on 3/26/09 with diagnoses of aftercare following surgery of the circulatory system, coronary atherosclerosis, hypertension, congestive heart failure and abnormality of gait. The discharge summary dated 4/29/09, lacked sufficient information to meet the definition of a compilation of information from progress notes. There was no mention of the patient ' s readmission to the hospital during the home health episode, or the resumption of care. The numerous lab work that was done for the medication, Coumadin, that was being taken by the patient was not mentioned in the discharge summary. Patient #2 was admitted to the agency on 3/14/09 with diagnoses of debility, sprain of the back, multiple sclerosis and hypertension. The discharge summaries dated 3/20/09 and 3/23/09, lacked sufficient information to meet the definition of a a compilation of information from progress notes. The summaries lacked documented evidence of detailed progress toward goals. The goals specifically addressed blood pressure readings and the distance the	H192	H192 449.797 1. Corrected discharge summaries were completed on patients #1,2,3,4 to reflect the written definition of the progress note. 2. The Administrative director reviewed at the mandatory staff meeting the procedure to complete a clinical discharge summary progress note. 3. The discharge summary progress note will be audited weekly for four weeks and thereafter, on a quarterly basis to verify compliance. 4. Administrative Director will monitor compliance and report audit results at QA/UR meeting on July 29, 2009. 5. Post survey, an order was located for patient #3 indicating the diagnosis and dressing change ordered, and signed by the physician (See attached order).	6/17/09 6/16/09 6/16/09 7/29/09 6/18/09

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H192	Continued From page 8 patient was to ambulate on the plan of care. Neither of these issues were addressed specifically in the discharge summaries with numbers that were related to the goals. Patient #3 was admitted to the agency on 4/24/09 with diagnoses of aftercare following orthopedic surgery, abnormality of gait and hypertension. Though care for a pressure ulcer was mentioned in the body of the plan of care, there was no diagnosis to support it. The discharge summary dated 5/22/09, lacked sufficient information to meet the definition of a compilation of information from progress notes. There was no mention of the patient ' s care by the home health aide. Patient #4 was admitted to the agency on 5/3/09 with diagnoses of aftercare following joint replacement, abnormality of gait and hypertension. The discharge summary dated 5/15/09, lacked sufficient information to meet the definition of a a compilation of information from progress notes. There was no mention of the patient ' s visit to the emergency room in the summary. The summary also lacked documentation of the many medication changes that took place during the episode of care. Severity 1, scope 2	H192		
H198	449.800 Medical Orders 6. Specific orders must be given for: (a) Rehabilitative and restorative care such as physiotherapy; (b) Skilled nursing and home health aide	H198		

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H198	Continued From page 9 care; (c) Nutritional needs; (d) The degree of activity permitted; (e) Dressings and the frequency of change; (f) The instruction of a member of the family in technical nursing procedures; and (g) Any other items necessary to complete a specific plan of treatment for the patient. This Regulation is not met as evidenced by: Based on clinical record review, the agency failed to provide specific orders from the physician for the changes to the plan of care for 2 of 5 patients sampled. (#3 and #5) Findings include: Patient #3 was admitted to the agency on 4/24/09 with diagnoses of aftercare following orthopedic surgery, abnormality of gait and hypertension. Patient #3 was seen by the home health aide during the episode of care five times, the order for the home health aide did not appear on the plan of care dated 4/24/09. The clinical record lacked documented evidence of any verbal orders for the change to the plan of care. Patient #5 was admitted to the agency on 4/10/09 with diagnoses of decubitus ulcer, ulcerative colitis, abnormality of gait, esophageal reflux, diabetes with peripheral circulatory disorder and hypertension. Patient #5 received a dietary consult on 4/11/09. The clinical record lacked documented evidence that there had been a physician ' s order for the service. Severity 2, scope 1	H198	H 198 449.800 1. Physician notified of error and need to correct the plan of care for patient #3 2. Plan of care corrected with proper dates for home health aide frequency. 3. Administrative director reviewed error with office support staff. 4. Administrative director will audit plan of care for proper dates for home health aide time four weeks. 5. Administrative director will report out at audit results at QA/UR meeting on July 29, 2009. 6. Post survey, an order was located for patient #5 indicating the MNT evaluation and signed by the physician (See attached order).	6/15/09 6/15/09 6/16/09 7/18/09 7/29/09 6/18/09

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H200	Continued From page 10	H200		
H200	449.800 Medical Orders 8. New orders are required when there is a change in orders, a change of physician or following hospitalization. This Regulation is not met as evidenced by: Based on clinical record review, the agency failed to obtain new orders for changes made to the plan of care for 3 of 5 patients sampled. (#1, #3 and #4) Findings include: Patient #1 was admitted to the agency on 3/26/09 with diagnoses of aftercare following surgery of the circulatory system, coronary atherosclerosis, hypertension, congestive heart failure and abnormality of gait. Skilled nursing visits were ordered for twice a week for three weeks, once a week for two weeks, and then reassess the need for skilled nursing. For the week of 4/12/09, there was a verbal order to decrease the skilled nursing visits to one time a week. The record lacked documented evidence of skilled nursing visits being provided for the week of 4/12/09. There were communication notes explaining why the visits were not made, but not physician notification or order. The record lacked documented evidence that the plan of care was updated to reflect the change. Patient #3 was admitted to the agency on 4/24/09 with diagnoses of aftercare following orthopedic surgery, abnormality of gait and hypertension. The patient was seen by the home health aide	H200	H 200 449.800 Patient #1 1. Reviewed with responsible nurse the correct documentation of a verbal order for graduated visits and the need clarify unclear orders with the physician. 6/16/09 2. Reinforced with the responsible nurse the expectation to update the plan of care as changes occur. 6.16/09 Patient #3 1. Physician notified of error and orders secured for the changes in the plan of care for patient #3. 6/15/09 2. Plan of care corrections include proper dates for home health aide visit frequency. 6/15/09 3. Administrative director reviewed error with office support staff. 6/16/09 4. Post survey an order to defer physical therapy until 4/27/09 was located (See attached order) which clarifies why PT visits were not performed during the week of 4/24/09. 6/16/09 Patient #4 1. Physician notified of error and orders secured for the changes in the plan of care for patient #4. 6/16/09 2. Plan of care corrections include proper dates for physical therapy visit frequency. 6/16/09 3. Administrative director reviewed error with office support staff. 6/16/09	

Bureau of Health Care Quality & Compliance

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	NVN3144HHA	A. BUILDING _____ B. WING _____	05/27/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAHOE FOREST HOME HEALTH SVC	10098 PINE AVE STATELINE, NV 89449

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H200	Continued From page 11 during the episode of care five times, the order for the home health aide did not appear on the plan of care dated 4/24/09. The plan of care dated 4/24/09 listed services to be provided as follows: Skilled nursing one visit. Physical therapy three times a week for two weeks. Occupational therapy once a weed for one week then twice a week for three weeks. The first week of care provided included skilled nursing and occupational therapy only. The record lacked documented evidence as to why the physical therapy was not provided as ordered. Patient #4 was admitted to the agency on 5/3/09 with diagnoses of aftercare following joint replacement, abnormality of gait and hypertension. Physical therapy was ordered on the plan of care dated 5/3/09 as three times a week for one week. The clinical record lacked documented evidence of a third visit being made on the first week of service to the patient. The clinical record lacked documented evidence of the physician being notified of the change to the plan of care. The nursing progress noted dated 5/6/09 listed an increase in the Lasix dosage to 20 milligrams a day. The medication record showed a change to the Lasix as 40 milligrams a day on 5/5/09. The clinical record lacked documented evidence of contact with the physician to clarify the order. The communication note for 5/9/09 revealed an emergency room visit and a change to the medications the patient was taking. The stool softener was to be discontinued and the patient	H200	3. The responsible nurse was counseled regarding the need to seek order clarification from the physician for unclear medication orders. 6/16/09 4. A late entry was placed on the nurses note reflecting the proper medication dose on patient #4 and the medication profile was updated accordingly. 6/16/09 5. The responsibilities of the nurses to clarify unclear physician orders and to properly document medication changes and update the medication profile was reinforced at the mandatory Home Health meeting. 6/16/09 6. Medication profile audits will be conducted for four weeks to verify the physician orders match the medication profile. 7/18/09 7. The Administrative director will report audit results at QA/UR meeting on July 29, 2009. 7/29/09	

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H200	Continued From page 12 was taking Tylenol as needed. Neither of these changes were noted on the medication record. The clinical record lacked documented evidence that an order had been obtained for the changes to the plan of care. The medication record listed the last review as being done on 5/14/09. Severity 2, scope 2	H200		